surgical procedure on the anulus," Fig. 2, *B* in our article clearly displays and states that 60% to 70% of the posterior mitral leaflet is excised, in essence, all of the central scallop of the posterior mitral leaflet. As such, about one third of the anulus of the posterior mitral leaflet is left without any leaflet attachments. By apposing the annular margins of the remaining leaflets, we reduce (plicate) the posterior anulus by at least 30%. As we state in the *Discussion,* "the placement of three to four interrupted, interlocking mattress sutures achieves this goal." The suture material is 2-0 polyester.

In essence, in our series this set of suture annuloplasties was sufficient to stabilize the posterior anulus. According to the article by Scrofani and associates,[1] they too "plicated with interrupted stitches (2-0 polyester)" the anulus "beneath the excised or transposed portion of the mural leaflet." What they do in addition is use the pericardial strip as a belt to further reinforce the basal mural suture plication.

I believe we do not strongly disagree with Drs. Scrofani and Santoli. Rather, we believe a localized series of inexpensive suture annuloplasties is sufficient in a vast majority of cases to produce a freedom from reoperation rate of 90% at 10 years in this retrospective, hence nonrandomized series of indeterminate selectivity (as all such series are wont to be). Drs. Scrofani and Santoli believe in their innovatively clever version of an annuloplasty ring, to be added to other believers of the half dozen or more other annuloplasty rings available on the market.

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12/8/79875

Pedicled pericardial flaps

To the Editor:

I congratulate Khoury and associates for the excellent results obtained with the Laennec group in Paris using pedicled pericardial flaps, a technique that we started together in the Bichat Hospital Paris in 1985.

I developed and used the flaps in eight patients (aged 6 months to 8 years) with tetralogy of Fallot for iatrogenic or congenital stenosis of their pulmonary artery branches (left pulmonary artery in four, right pulmonary artery in one, and bifurcation in four). The follow-up is now between 5 and 10 years, with superb results except for one failure resulting from technical difficulties during the operation.

Between July 1989 and July 1992, I also used pedicled pericardial tubes in 12 patients with tricuspid atresia to bridge the inferior vena cava to the main pulmonary artery for bicaval to pulmonary artery connections. The mean age of the patients was 4 ± 2.8 years and mean body weight was 10.5 ± 4.9 kg. The follow-up is 4 to 7 years, with stable clinical results and enlarged conduits in the three patients who have had angiograms.

We stopped using the technique because our hospital no longer treats pediatric patients, so I can only show gratitude toward Wassim Khoury and Francine Leca for taking an interest in the technique and proving its results.

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[Response declined]

Transmanubrial approach to the thoracic inlet

To the Editor:

We fully agree with Nazari's opinion[1] about the disadvantages of clavicle resection in the transcervical approach to apical chest tumors. Anyone who is familiar with the transclavicular approach has experience with the deformity (Fig. 1) and discomfort caused by (1) the shortening of the acromiosternal distance, (2) the paradoxic and painful movement of the free distal part of the clavicle, (3) the instability of the scapular girdle, of which the only point of attachment is the sternoclavicular joint, and (4) the disinsertion of the sternocleidomastoid and the pectoralis major muscles.

Our approach to avoid these deformities is quite different, for three reasons.

1. In our experience, the reinstallation of the disarticulated clavicle leads either to luxation of the sternoclavicular joint when fixed only with metallic stitches, because of the strength of the scapular movements, or to an arthrodesis, with important limitation of scapular mobility, when fixed with a screw or Sherman's plate.

2. The sternomastoid muscle is the major component of cervical spine stability. Its disinsertion, even after careful reconstruction, leads in all cases to a progressive cervical scoliosis.

3. The radical treatment of lung cancers, including apical tumors, must respect oncologic principles. At the very least an upper lobectomy, associated with a medias-